Original Article

A journey of the experiential world of COVID-19 survivors: From myth to reality

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Abstract

The purpose of this study is to explore the experiences of COVID-19 survivors. This is a qualitative study using descriptive phenomenology. Data have been collected from 15 COVID survivors using purposive sampling. Six major themes emerged: experiential reality, psychological distress, coping strategies, fortifying primary & secondary social groups, treatment regime, and post-traumatic experiences. It is found that initially, COVID was perceived as a myth and media hype. Awareness of the disease spread gradually, and people took proper precautions.

Keywords: COVID-19, psychosocial effects, Phenomenology

Introduction

The outbreak of different diseases has been persistent throughout human history, but not all reached the level to be declared a pandemic (Archer-Diaby, 2020). Even then, the world has witnessed many pandemics in known history, like the Athenian plague (430 BC), the Antonine plague (165–180 AD), the Justinian Plague (mid-16th century AD), the Black Death (Plague) (1334-1400 AD), Spanish Flu (1918–1920), HIV/AIDS (since the 1980s), Smallpox Outbreak (1972), Severe Acute Respiratory Syndrome (SARS) in 2003, Swine Flu (2009), and Ebola (2014-16), (Huremović, 2019; Sampath et al., 2021). The recently declared pandemic by WHO is new coronavirus disease 2019 (COVID-19) (Sampath et al., 2021).

Modern means of communication have not only facilitated human travel but have also allowed viruses to be transferred from one place to another, from one continent to the other (Archer-Diaby, 2020).

The COVID-19 outbreak started in China and spread all over the world. Pakistan was no exception; cases began to be reported, and the first case was reported in February 2020 (Waris et al., 2020). Initially, people did not bother, but gradually the virus spread around the country, and the

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government was compelled to decide countrywide lockdown. Offices and educational institutes were closed, and operations went online. Markets were open for a limited time so that people could buy groceries and other items. People started to get infected, the number of infected people started to rise, and the death toll began to increase (Waris et al., 2020).

This situation had psychological, social, and economic effects. Media were reporting infection rates and mortalities hourly, and people were scared. Many myths about Coronavirus existed, and many remedies got popular among the people. International news, mainly from Europe, was horrifying, and the situation in the neighboring country of India was grave.

This phenomenological study aims to understand and discover the perceived psychological and social effects of COVID-19 on survivors of the disease. At this stage in the research, COVID-19 will be generally defined as a contagious disease that has been declared a pandemic by the World Health Organization (WHO).

Literature Review

A pandemic wave emerged from China city of Wuhan, carrying the coronavirus infection around the globe. The common symptoms include fever, myalgia, fatigue, and dry cough, along with other referred symptoms of nausea, vomiting, and diarrhoea (Chen et al., 2020; Shi et al., 2020). World Health Organization (WHO) exclaims that 80% of people have recovered from the disease and show no symptoms afterwards (Jebril, 2020). Coronavirus is contagious and can spread from one person to another (Yang & Wang, 2020). Alongside the physical symptoms in COVID-19 patients, psychological and social effects and influences were observed and studied among survivors of the disease.

In a study by Xiang et al. (2020), it was found that people who tested positive for the virus seemed to have high rates of fear and anxiety regarding the consequences of the infection, which may lead to shortness of breath and worsening symptoms of Coronavirus. People tend to stay at home, and this quarantine situation has aggravated negative psychological symptoms that can last long (Brooks et al., 2020). Duan and Zhu (2020) conducted a study in China, and they claimed that there were other related psychological and social symptoms, such as depression, anxiety, loneliness, depression, anger, and boredom which negatively affected patients' mental health overall.

Mazza et al. (2020) concluded in a study with colleagues that, like other viruses, COVID-19 is associated with psychiatric consequences. In this study, 55% of the sample showed that there must be at least one mental

disorder in patients surviving COVID-19. The more period spent in hospitalization for the treatment of Coronavirus, the more psychological impact can be seen among surviving patients (Mazza et al., 2020). The results also depicted the gender differences in suffering from psychological health issues among COVID-19 patients, according to which the females suffered more than males and were rated with high scores in all the measures applied for the study, including psychological measures (Mazza et al., 2020).

Most commonly and as expected, the risk factors of Post-Traumatic Stress Disorder seemed to prevail among COVID-19 patients after the pandemic outbreak (Liu et al., 2020). There can be psychopathological consecution due to coronaviruses as this viral infection directly affects the central nervous system, or it may indirectly affect the immune system (Wu et al., 2020). Thus, the immune system's response to coronaviruses may cause psychiatric symptoms by triggering neuro-inflammation (Dantzer, 2018). This inflammation is supposed to raise the psychopathology impacts, ultimately leading to psychological stress and stress-related infection (Miller & Raison, 2016).

Studies have been carried out since the outbreak of the 2020 pandemic. Still, results of previous pandemic situations show that there is a prediction for survivors of the virus, in this case, COVID-19 survivors, of being at high risk of developing psychological symptoms of depression or PTSD (Mak et al., 2009), which can be dependent upon personal traits of patients such as resilience, social support availability and its quality in addition to worries regarding recovery from illness (Bonanno et al., 2008).

There are some other experiences in COVID-19 patients in addition to immunological mechanisms such as fear of illness, vague future, fear of being labelled, illness-related distressing memories, and social remoteness and feelings of loneliness which are considered substantial psychological stressors that may lead to psychopathological consequences (Brooks et al., 2020).

In Pakistan, several factors affect mental health amid COVID-19, including impaired psychosocial, psychological, and emotional functioning. Due to quarantine, people are uncertain of novel disease, risk of self-isolation, and social distancing. This has harmed an individual's normal social life and interpersonal issues. (Mukhtar, 2020). COVID-19 can have a destructive influence on people's psychological and mental health. These influences lead to psychological suffering, anguish, stigma, PTS symptoms, substance abuse, anxiety, stress, and depressive symptoms, along with feelings of worry concerning socioeconomic status (Mukhtar, 2020).

In a study by Rogers et al. (2020) on COVID-19 survivors, they were found to be having inflated rates of PTSD along with depressive symptoms, anxiety, insomnia, and Obsessive-Compulsive symptomology. In a study by Mazza et al. (2020), there was expected to be a higher-than-average incidence of PTSD, major depression, and anxiety among COVID-19 survivors. In addition to this information, it is observable that there are many factors responsible for mental health issues during the COVID-19 break, which are psychosocial. These factors cover social isolation, loneliness, anxiety, fear, hopelessness, genuine worries regarding the security of a job, provision of supplies, and concerns about ending the virus (Armitage & Nellums, 2020).

For studying the psychological and social effects among COVID-19 survivors, it is crucial to notice the pathway it is taking. There must be some reasons behind the infection leaving marks on mental health and leading towards psychosocial consequences. Relevant to these reflections, it has been suggested that this virus contagion can announce cytokine storm resulting in programmed cell death, referred to as pyroptosis, which is common in virus infections (Shi et al., 2020). This process can lead to an unregulated inflammatory reaction that can facilitate various organ failures(Tay et al., 2020). In COVID-19 survivors, these neurological processes and brain neural circuits may get damaged, possibly when the immune deposit is harmed in brain circuits.

This immune-inflammatory damage can make the body vulnerable biologically and psychologically as well. The body is now at risk of numerous psychosocial and psychopathological issues weakening the patient's overall mental health (Dinakaran et al., 2020). Neufeld et al. (2020) study shows that ICU survivors of COVID-19 are at intensified risk of psychological impacts. Another study found that almost one-third of ICU survivors suffer from depressive symptoms and anxiety after the first year of recovery (Bienvenu et al., 2018). As mentioned above, PTSD symptoms are found to be most prevalent among COVID-19 survivors and show clinical symptoms which can have a severe and long-lasting impact on one's life overall (Bienvenu et al., 2018).

Dealing with these issues among COVID-19 patients is substantial so that they may cope with disturbing psychological and social conditions after survival. ICU diaries written by family members or hospital staff summarizing patients' daily activities may be effective (McIlroy et al., 2019). These diaries may improve psychological recovery and weaken negative psychosocial (Aitken et al., 2013). These often help to fill the memory gap for patients and assist them in creating a sense of coherence and endurance in life, thus improving the social relations of COVID-19 survivors (Aitken et al., 2013).

The symptoms of PTSD can be seen to reduce once social support from family and friends is provided consistently, thus ultimately improving mental health and quality of life among survivors of the disease (Tingey et al., 2020).

Research Methodology

This is exploratory research using qualitative methodology. Phenomenology has been used as the qualitative research approach. As illustrated by Creswell and Poth (2018), "a phenomenological study describes the common meaning for several individuals of their lived experiences of a concept or a phenomenon." (p.121). Phenomenology is a thoughtful and value-free reflection on the lived experiences of humans (Van Manen, 2016). This experience could be human emotions or disease (Moustakas, 1994).

Creswell and Poth (2018) have discussed two broad categories of phenomenology, one by van Manen (2016), termed hermeneutic phenomenology and the other psychological phenomenology proposed by Moustakas (1994). Another important category of phenomenology is descriptive phenomenology which deals with the essence or essential structure of lived experiences (Morrow et al., 2015). The work of (Colaizzi, 1978) and (Giorgi, 1985) is of immense importance in descriptive phenomenology. However, the method of (Colaizzi, 1978) has been extensively used in health sciences (Morrow et al., 2015). In this study (Colaizzi, 1978), methodology has been used. However, for data analysis (Gioia et al., 2013) methodology is used. In (Gioia et al., 2013) methodology, important quotes of the informants are called first-order concepts, these first-order concepts are then clustered under second-order themes, and second-order themes are clubbed in aggregate dimensions. The whole process is then exhibited in a diagram that is called a data structure (Gioia et al., 2013). Though (Gioia et al., 2013) used this data analysis for grounded theory; however, authors have found it equally effective in phenomenology, as qualitative research is all about extracting important themes from data and reflecting on those.

A total of fifteen informants participated in the study. All these were COVID survivors. Semi-structured interviews were conducted online (google meet), through phone calls, and in person. All the interviews were audio recorded with the consent of the informants. The interview duration varied from 30 minutes to 45 minutes.

Procedure

In this study, the procedure explained by (Colaizzi, 1978) has been used as it deals with psychological phenomenology. It consists of

familiarization, identification of important statements, formulating meanings, clustering the themes, developing an exhausting description, producing the fundamental structure, and seeking verification of the fundamental structure (Colaizzi, 1978).

All the interviews were audio recorded and then transcribed. Transcripts were read repeatedly to familiarize the data as prescribed by (Colaizzi, 1978). Repeated readings of the transcripts helped identify the important themes; for example, one informant said, "I feared death." The survivors' statements are the 1st order concepts, written exactly as the informants told (Gioia et al., 2013). A number of 1st order concepts emerged at this stage which were again analyzed, and similar 1st order concepts were clubbed under one 2nd order theme. This procedure was repeated for all the concepts. 2nd order themes helped develop an aggregate dimension explaining the phenomenon related to those particular themes (Nag & Gioia, 2012).

Sampling

In phenomenology, all the study participants must experience the phenomena under investigation (Creswell & Poth, 2018). As COVID-19 was the focus of the study, the sample constituted those individuals who were confirmed or perceived COVID positive patients. Purposive sampling is best suited in situations where subjects qualify for a specific purpose (Bryman & Bell, 2015; Saunders et al., 2011; Sekaran & Bougie, 2003). Data were collected from fifteen informants using semi-structured interviews. This type of interview is preferred as it is flexible and allows for improvisation according to the situation (Bryman & Bell, 2015). In a phenomenology study, data can be collected using any source (Colaizzi, 1978). These sources can be face-to-face interviews, written narratives, or online mediums (Morrow et al., 2015). In the current study, face-to-face, online (using google meet) and telephonic interviews have been used to collect data from the informants.

Sample Size

In phenomenology, data from 5 to 25 informants is sufficient to ascertain the lived experience of the informants (Polkinghorne, 1989). According to Creswell and Poth (2018), a heterogeneous group of 3 to 4 or 10 to 15 informants to explore the lived experiences of the individuals may be used. A sample of 5 to 25 informants in a qualitative study is considered sufficient (Steinar, 2007).

Data Analysis & Discussion

Table 1 provides the details of the informants.

Table 1: Details of informants

Informant	Gender	Age	Marital Status	Mode
1	Male	50	Married	Online
2	Male	49	Married	Online
3	Male	39	Married	In-person
4	Female	39	Married	In-person
5	Female	25	Married	Online
6	Male	37	Married	Online
7	Male	16	Unmarried	In-person
8	Male	14	Unmarried	In-person
9	Male	69	Married	On phone
10	Male	55	Married	Online
11	Male	47	Married	On phone
12	Male	34	Married	On phone
13	Male	48	Married	Online
14	Male	25	Married	Online
15	Male	27	Married	Online

Figure 1 depicts the data structure of the questions related to getting infected by COVID. Five 2nd order themes emerged: perceptions, precautions, symptomatic experiences, confirmation, and perceived susceptibility.

Perceptions depict the notions held by the informants regarding the pandemic. Many people in Pakistan considered COVID-19 as a myth and foreign propaganda. We asked people about their perceptions regarding COVID. One informant replied, “I thought there was no COVID, and all these were false information as there was nobody sick in my social circle and my friends or family, so we did not take it seriously initially, and this is just a foreign agenda”. This informant was so severely infected that he spent 25 days in ICU on the ventilator. One informant told, “I had no doubts about this disease.” People had different views before getting infected. Some had no doubts that it was a virus that caused this pandemic and they needed to follow SOPs. One informant said, “Yes, I know it is due to one virus. It causes chest infection, could cause death.” An informant told, “my child had a fever around 100 F, and I took him to a paediatrician who was a professor; I asked him do

you suspect my child COVID positive? The doctor laughed and said there is nothing like COVID, don't believe in this." Later, the doctor himself fell prey to COVID. Some people considered this a hype created by the media.

We asked the informants about the precautions they took to avoid COVID. People reported following SOPs like social distancing, sanitizing, wearing face masks, and wearing gloves. However, some people didn't believe in the precautions and didn't follow any. People were asked to share the symptoms they experienced related to COVID; the most common symptoms were fever (mild to severe), cough, sore throat, severe body pain, loss of smell and taste and flu-like symptoms, which have been clubbed under the second-order theme 'Symptomatic Experiences'.

One of the interesting phenomena was the confirmation of the COVID. Getting a COVID test has some associated issues; first, for a COVID test, the person must provide his/her National Identity card Number to the diagnostic lab; the information goes into the national health database, and the person is traceable. These measures for some people were intimidating, and people tried to avoid COVID testing. Second, it is still an expensive test; it costs from Rs. 4000 to Rs. 6000 if done by a private lab; this is a big amount, and if there are 3-4 persons, the cost goes even higher. So, the cost factor also prohibited people from going to COVID testing. However, knowing the economic conditions, doctors too relied on symptomatic diagnosis and less costly tests like Complete Blood Count (CBC), chest X-ray and use of an oximeter when required. More than 50% of the informants (08) didn't undergo PCR tests to diagnose COVID. But they were declared COVID-positive based on these mentioned measures.

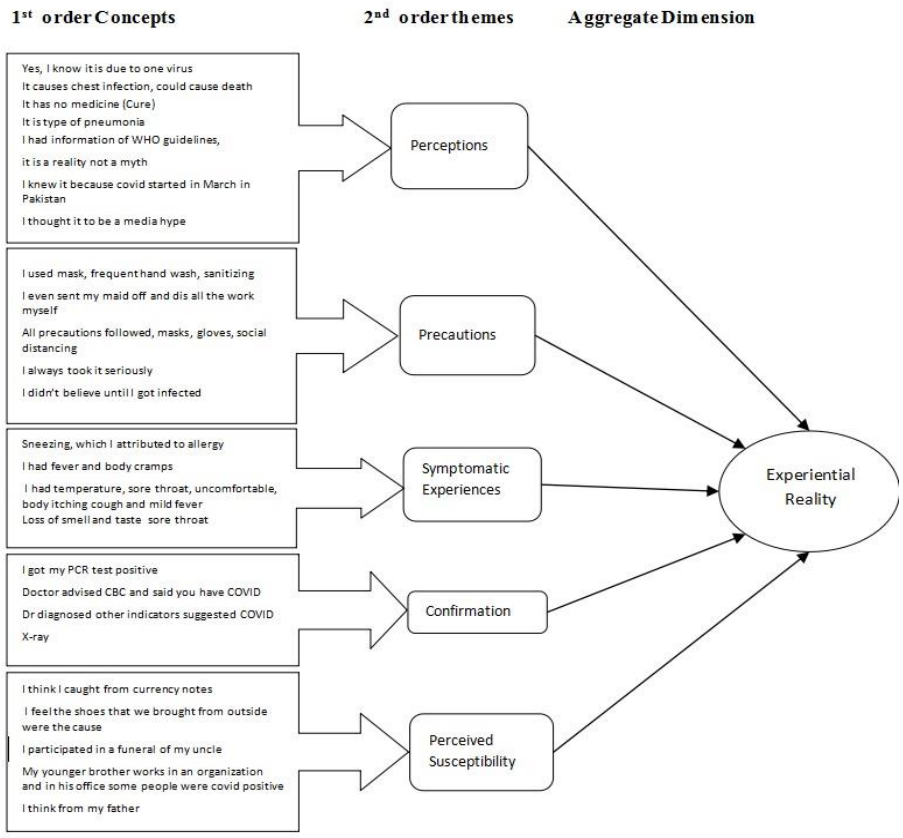

Figure 1: Getting Infected

We asked informants, "in your opinion, how did you get infected?". People replied based on their perceptions. The 2nd order theme that emerged is 'Perceived Susceptibility'. One informant said, "I think I got it at a barber's shop," and another suspected currency notes and another informant thought ", I got it from my father as he was the first one to get sick". 2nd order themes, perceptions, precautions, symptomatic experiences, confirmation, and perceived susceptibility made up the aggregate dimension of 'Experiential Reality'. Experiential reality is an experience that informants underwent in the real world; whatever notions and perceptions they held about COVID became a reality. Those who thought it propaganda or myth now had to believe it was a bitter reality. They experienced trauma, body pain, high-grade fever, weakness, and loss of senses of taste and smell. Some even faced severe shortness of breath, and one was shifted to ICU. After getting sick, whether the PCR test was done or not, peoples' experiential learning made them believe the severity and reality of COVID-19.

Informants were asked about their feelings during the disease, the reactions of the family and relatives, and the severity of the disease. Five 2nd order themes emerged from several 1st order concepts, including initial reaction, death anxiety, skepticism, social isolation, and stress. Figure 2 shows the data structure that emerged from the informants' responses. At this stage, the informants were experiencing the disease (COVID) whether they had done PCR tests or otherwise diagnosed by their doctors.

Initial reactions of the informants were mixed; some could not believe it and were shocked, some were not surprised, and a few knew sooner or later, it had to happen; an interesting comment was made by a boy of 14 years "I was not much worried rather I was happy that now I will not have to study."

Some informants were traumatized and feared horrible consequences, hospitalization, and ICU; some feared death. One informant told, "I wrote my will; I thought I might die." A female informant explained, "I was afraid of getting admitted to the hospital; I thought people didn't return alive from the hospital; my grandmother had died of COVID". People who got sick were afraid for their health and survival, as a 69-year-old informant told, "My survival was difficult as I was 69 years." It was common that COVID was deadly for older and weak people. All these people were facing "death anxiety" as they feared death.

A rumour was common that the government was getting funds for each COVID positive patient and more funds from foreign agencies for deceased persons. This rumour created "skepticism" among the general public and especially among admitted patients. An informant hospitalized due to poor condition said, "Rumours that doctors kill the patients terrified me."

Whoever was diagnosed with COVID had to isolate and go in quarantine; this was necessary. People had different feelings about this 'Social Isolation'.

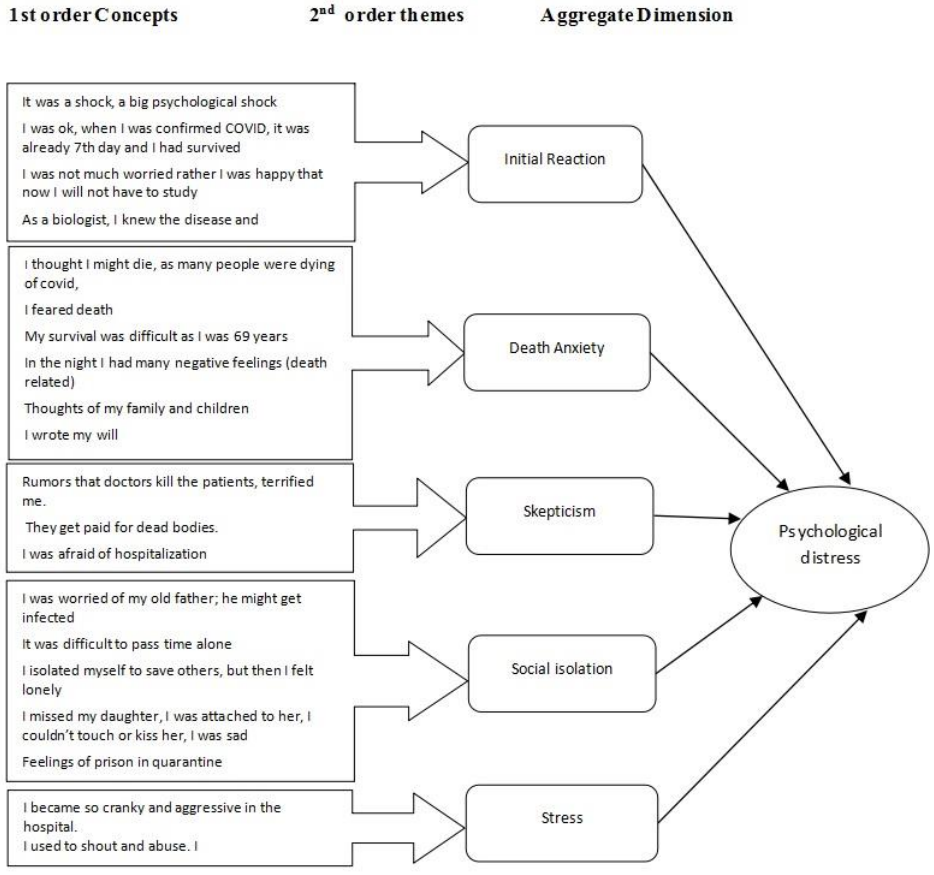

Figure 2: Feelings during illness

Another theme that emerged was 'stress'. Apart from the feelings of trauma and disease, people were also stressed. Living in quarantine meant social isolation for at least 15 days, which was tough. It was more difficult for individuals who were alone in this social isolation. A family of 07, including 05 children (ages 5-16 years), spent 04 weeks in quarantine in a house with other issues, like children's boredom. The father said, "when the children were so tired, I took them with me in my car and had a round of the town, with closed windows; this became our routine in the evenings". People experienced different issues during the isolation period, which caused stress.

Initial reaction, death anxiety, skepticism, social isolation, and stress lead to the aggregate dimension of psychological distress. As cited by Ridner (2004), "'psychological distress refers to the general concept of maladaptive psychological functioning in the face of stressful life events". Psychological distress has five characteristics: perceived inability to cope effectively,

change in emotional status, discomfort, communication of discomfort, and harm (Ridner, 2004). People getting infected by COVID-19 showed most of these symptoms. They faced discomfort caused by body pain, high-grade fever, and emotional issues; as one informant said, "I missed my daughter, I was attached to her, I couldn't touch or kiss her, I was sad". They also communicated the discomfort faced during the illness. Psychological distress remained even after the recovery as some of the informants were afraid of getting infected again.

Informants were asked how they spent time during illness and isolation and how they fought against COVID. From their responses, four 2nd order themes: Religious activities, social media & Entertainment, Engaging, and Defensive Behavior emerged, which have been shown in figure 3(a) Combating strategies which is the data structure.

All the informants were Muslim by religion and mostly took refuge in religious rituals. They recited the holy Quran, listened to the recitation of Sura Rahman, read religious books, and offered prayers regularly. This is quite understandable; whenever people are in pain and fear, they connect to Allah, giving them spiritual relief. During difficult times Muslims offer special prayers and divert themselves to Islamic teachings, as one informant told, "I was in ICU and could barely move, but I offered prayers on the bed by gestures only". A female said, "in the day, mostly recitation of Sura Rahman was listened to, which was termed as Rahman therapy and recommended by my relatives". Those who could not offer prayer only listened to Sura Rahman; see one comment "I was too weak to do anything, just listening to Quran."

Apart from religious activities, people used the internet and cable TV to spend their time and divert their attention from their illnesses.

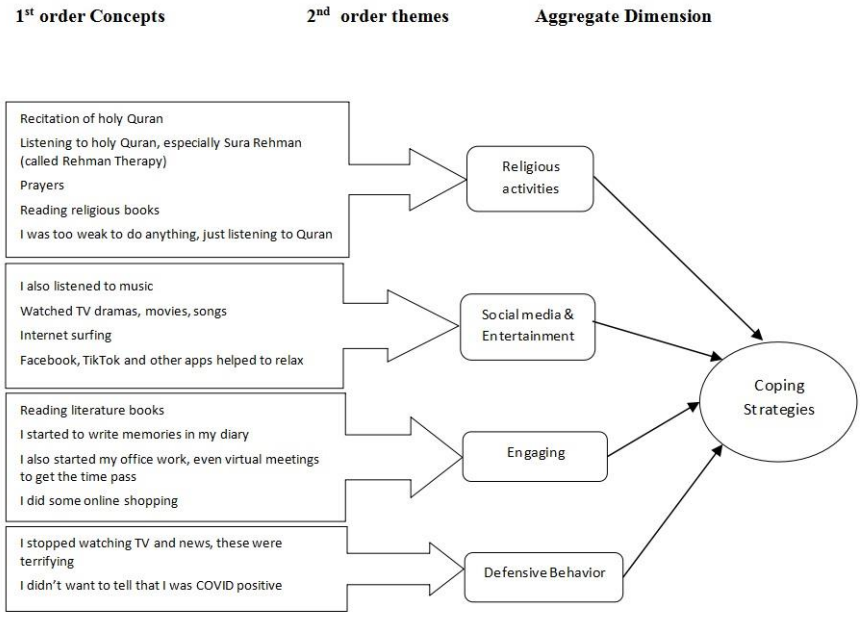

Figure 3(a): Combating the disease

Informants listened to music, watched movies and dramas, and used social media like Facebook, Twitter, WhatsApp, and TikTok. A family quarantined in a house bought a heavy internet package and used social media as the young boy said, "my father had bought a good weekly package of internet data; we watched movies and cartoons." Spending time in isolation becomes difficult once it is established that a family is COVID-positive, so social interaction has to be limited. Hence, people use social media and entertainment to spend time.

Not all were fond of using social media or the internet to spend time. Some people used this time to engage in literary readings, do official tasks, and write memoirs. A professor said, "I started to write my memories of this isolation period". During the lockdown period, women also did some online shopping as businesses pushed online selling, especially for women's clothing. The second-order theme, "engaging", encompasses all such activities.

Another second-order theme that emerged from 1st order concepts was "defensive behavior". There was information overflow in the media regarding the COVID pandemic, and many people felt threatened and vulnerable, especially news of casualties caused by the virus was intimidating. To block such information, many people stopped watching the news to avoid further fear. The doctors and relatives advised those who got infected not to get

indulged in information gathering, which helped to some extent. For example, one article said, “I stopped watching TV and news; these were terrifying.” People tried to hide their status of getting infected to avoid unnecessary social advice, social stigma and unwanted sympathies. As one informant revealed, “I didn’t like phone calls of friends and relatives.”

Religious activities, social media & entertainment, engaging, and defensive behavior formed the aggregate dimension of coping strategies. All these were the coping strategies during the illness. People become more religious and pray to Allah during difficult times; they seek spiritual satisfaction through this act. Moreover, according to the personality, circumstances and severity of the disease, people indulged in different activities, especially the children focused more on net surfing and social media.

The data structure presented in figure 3(b) portrays another dimension of the illness and quarantine period. This period lasted from 03 to 04 weeks generally. Imagine a family socially isolated for 3-4 weeks in the house; apart from other activities like social media & entertainment along with religious activities, what else could they have done? One informant explained the time spent in illness as “Feelings of prison in quarantine”. Several 1st order themes emerged, revealing that this is not just a difficult and painful time but a special time too. For example, one female informant expressed, “We had plenty of time to spend together after such a long time.” So, this quarantine gave a break too, from the busy schedules of the people and families spent a very close time with each other. Another informant expressed, “This quarantine brought one thing special, after 20 years of married life, we had not much to share, here we rediscovered our relationship.” So, the 2nd order theme has been labelled as ‘rediscovering relationship’. The quarantine period brought family members closer and strengthened family ties.

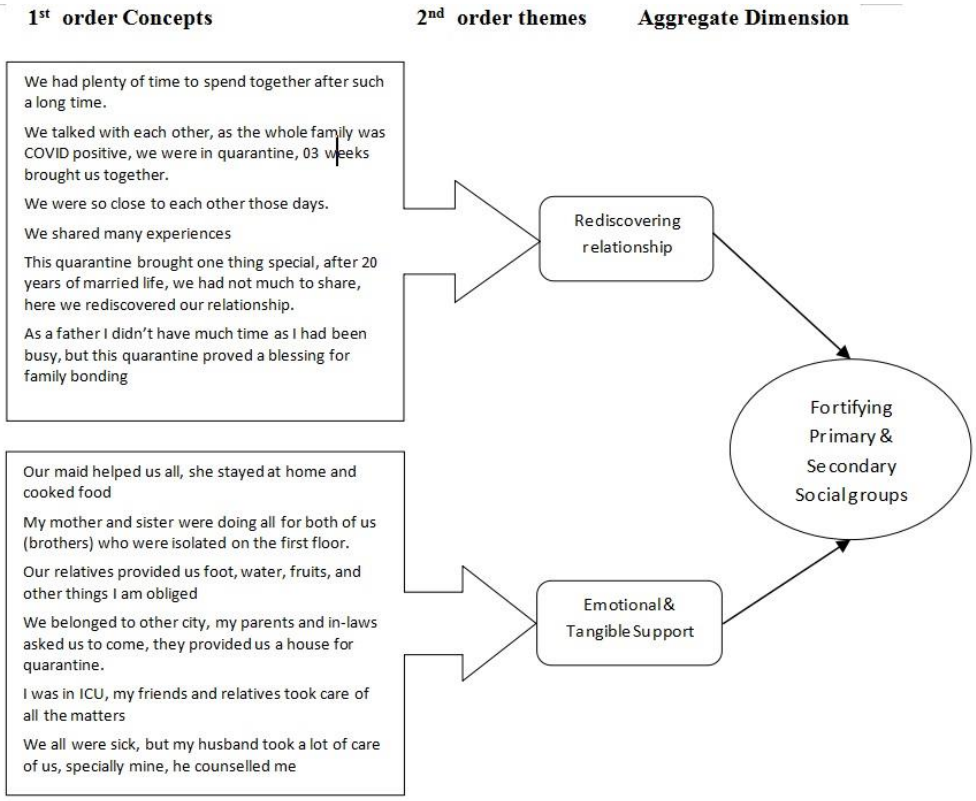

Figure 3(b): Combating the disease

Pakistani society is collectivist; people are knitted in their relationships and help each other in their hour of need. The same happened in the COVID outbreak; on the one hand, people were concerned about the spread of the virus, and on the other hand, infected families were not abandoned. This sample includes two families who were all infected and quarantined in separate rooms and two brothers in one house who were infected and stayed in the upper portion of the shared house where other family members lived. According to one survivor, "my younger brother and I were infected, and we stayed in the upper portion, my sister, mother and another brother we on the ground floor; they provided all the food, medicine and other necessary things". This is an example of a caring family who cared for their infected member. Another family quarantined in a separate house was taken care of by the relatives, who provided all the food, water, medicine, and fruits. And the house was vacated for them by another relative as these members came from another city. The head of the family told, "We belonged to another city; my parents and in-laws asked us to come, and they provided us with a house for quarantine." Another informant said, "Our maid helped us all; she stayed

home and cooked food." An informant who was hospitalized and spent one month in ICU told, "I was in ICU; my friends and relatives took care of all the matters". There were several examples of how people helped each other when they required the most. People backed up each other emotionally as well. Based on these 1st order concepts, a 2nd order theme, 'Emotional & Tangible Support' was extracted.

'Emotional & Tangible Support' and 'Rediscovering relationship' formed an aggregate dimension 'Fortifying Primary & Secondary Social groups. The primary social group is the family members like siblings, while the secondary social group consists of friends and relatives. These groups were strengthened in such circumstances as people helped each other during testing time.

The most common medicines prescribed were paracetamol, azithromycin, and cough syrups. In severe issues, along with these medications, the patients took Ceftriaxone (IV) injections, steroids, nebulization, and steam. We term this as medical advice. However, in Pakistani society, there is too much social advice; the most common social advice was using steam, ginger tea, mutton soup, and other herbal fluids. Though doctors didn't recommend such, these were used. Medical and social advice constitute the aggregate dimension of the 'Treatment Regime'. Data structure related to this is shown in figure 4.

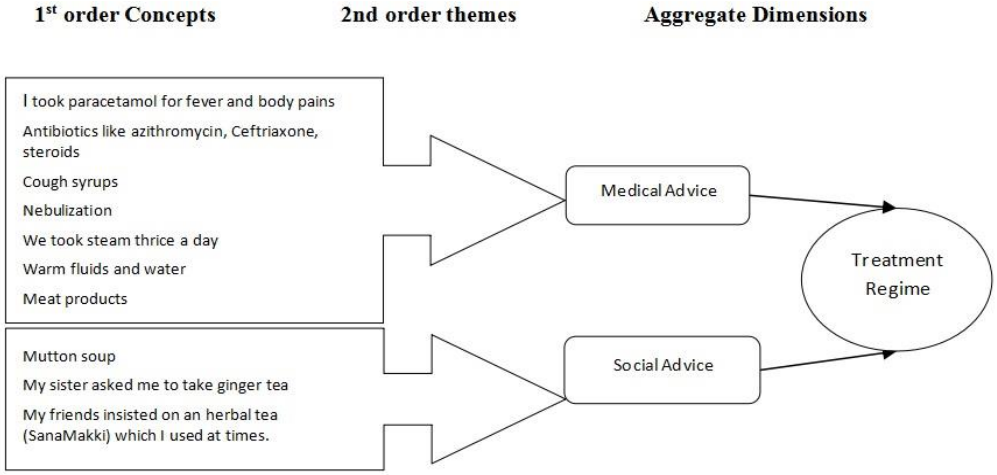

Figure 4: Getting Recovered

We asked the informants how do you feel after surviving COVID. Two types of aftereffects were reported, physical and psychological, as shown in

figure 5. The most frequent physical aftereffects included weakness, low-grade fever, and joint pain. One old informant reported, “My hearing was affected”, and another said, “My eye-sight was affected”. However, these were less reported effects.

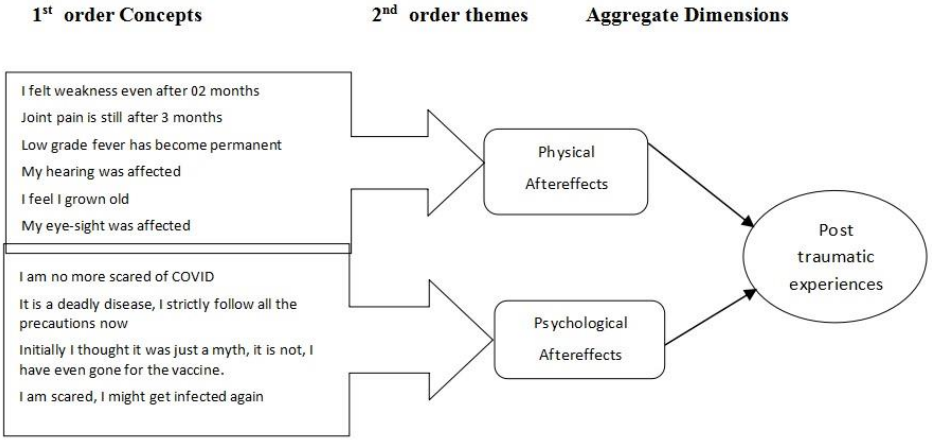

Figure 5: Post disease effects

Some informants were no longer afraid of COVID. “I am no more scared of COVID,” said an informant. However, some were more scared “It is a deadly disease, I strictly follow all the precautions now”, “Initially I thought it was just a myth, it is not, I have even gone for the vaccine.”, and “I am scared, I might get infected again”. Physical and psychological aftereffects formed the aggregate dimension of “Post traumatic experiences “. These experiences vary according to the severity of the disease endured by an individual.

Conclusion

COVID-19 is a stressful disease; it has physical and psychosocial consequences. People experience psychological distress and social isolation. Fear of death is common due to media hype; people avoid media as a defensive behavior. In a collectivist society like Pakistan, family, relatives, and friends provide emotional and tangible support to face this deadly disease. The quarantine period also provided some special moments to rediscover the relationships.

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